IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1979

Nos. 79-4, 79-5, 79-491

JASPER F. WILLIAMS, M.D., et al.,
Appellants,
v.
DAVID ZBARAZ, M.D., et al.,
Appellees.

BRIEF AMICI CURIAE ON BEHALF OF THE PHYSICIANS NATIONAL HOUSESTAFF ASSOCIATION, THE MEXICAN AMERICAN WOMEN'S NATIONAL ASSOCIATION, THE PUERTO RICAN LEGAL DEFENSE AND EDUCATION FUND AND THE NATIONAL CONFERENCE OF BLACK LAWYERS.

DOROTHY T. LANG
LUCIEN WULSIN, JR.
National Health Law Program
2401 Main Street
Santa Monica, CA 90405
(213) 392-4811
Attorneys for the Physicians
National Housestaff Association

VILMA S. MARTINEZ
CARMEN A. ESTRADA
Mexican American Legal Defense
& Education Fund
28 Geary Street
San Francisco, CA 94108
(415) 981-5800
Attorneys for the Mexican American
Women's National Association

M.D. TARACIDO
PETER BIENSTOCK
LIZETTE A. CANTRES
Puerto Rican Legal Defense &
Education Fund
95 Madison Avenue
New York, NY 10016
(212) 532-8470
Attorneys for the Puerto Rican
Legal Defense & Education Fund

VICTOR GOODE
LAUREN ANDERSON
National Conference of Black Lawyers
126 W. 119th Street
New York, NY 10026
(212) 866-3501
Attorneys for the National Conference
Of Black Lawyers

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1979

Nos. 79-4, 79-5, 79-491

JASPER F. WILLIAMS, M.D., et al.,
Appellants,
v.
DAVID ZBARAZ, M.D., et al.,
Appellees.

BRIEF AMICI CURIAE ON BEHALF OF THE PHYSICIANS NATIONAL HOUSESTAFF ASSOCIATION, THE MEXICAN AMERICAN WOMEN'S NATIONAL ASSOCIATION, THE PUERTO RICAN LEGAL DEFENSE AND EDUCATION FUND AND THE NATIONAL CONFERENCE OF BLACK LAWYERS.

DOROTHY T. LANG
LUCIEN WULSIN, JR.
National Health Law Program
2401 Main Street
Santa Monica, CA 90405
(213) 392-4811
Attorneys for the Physicians
National Housestaff Association

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases — Page

Federal Cases — Page

Miscellaneous — Page

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1979

Nos. 79-4, 79-5, 79-491

JASPER F. WILLIAMS, M.D., et al., Appellants,

v.

DAVID ZBARAZ, M.D., et al., Appellees

BRIEF AMICI CURIAE ON BEHALF OF THE PHYSICIANS NATIONAL HOUSESTAFF ASSOCIATION, THE MEXICAN AMERICAN WOMEN'S NATIONAL ASSOCIATION, THE PUERTO RICAN LEGAL DEFENSE AND EDUCATION FUND AND THE NATIONAL CONFERENCE OF BLACK LAWYERS.

QUESTIONS PRESENTED

1. Does Title XIX require the states to provide an irreducible minimum of medically necessary care in the five basic service categories to the mandatory eligibles?

2. May a state discriminate in its provision of a mandatory service based on the diagnosis, type of illness or condition?

3. Are a state's Title XIX obligations for specific services hinged upon the availability of a fixed percentage of federal funding for each of those services?

INTEREST OF AMICI CURIAE

This brief is filed with the consent of all parties to this appeal, pursuant to Rule 42.

The Physicians National Housestaff Association (PNHA), headquartered in Washington, D.C., is a professional organization of 12,000 interns and residents who staff this nation's teaching hospitals. PNHA's chapters are located throughout the country, including one in Chicago, Illinois. The purpose of the organization is to improve the working conditions and the quality of patient care in public hospitals. PNHA's members perform a large number of the Medicaid abortions that occur in the United States, as well as deliver a large number of the Medicaid babies born in this country from both normal and high risk pregnancies. PNHA's members are concerned that their inability to perform all

medically necessary abortions for their indigent patients will adversely affect their ability to care properly for, and damage the health of, those patients.

The Mexican American Women's National Association (MAWNA) was formed in 1974 to represent the interests of over three million Mexican American women in this country. The organization, headquartered in Washington, D.C., was created to establish a national forum by which Mexican American women can advocate on issues of concern to them and create public awareness of those concerns. MAWNA has had a long-standing interest in health issues in general and reproductive rights issues in particular. MAWNA is concerned that the inability of indigent Mexican American women to choose and obtain medically necessary Medicaid abortions will have an adverse impact on the status of Mexican American women's health in this country.

The Puerto Rican Legal Defense and Education fund (PRLDEF) is a non-profit corporation located in New York City. Its purpose is to defend the interests of Puerto Ricans and other Hispanics in the

United States by providing representation on issues of concern to that community, which statistics indicate may be the poorest minority in the United States. PRLDEF is concerned that the inability of indigent Puerto Rican women to choose and obtain medically necessary abortions will have an adverse impact on their health, their ability to obtain and retain employment and to raise their children.

The National Conference of Black Lawyers (NCBL) is comprised of 1500 Black lawyers, judges, law professors and law students. NCBL was chartered to work for the elimination of racism in the law and to address the problems of the Black community. Thus, NCBL is concerned with the discriminatory impact on poor minority women of a failure to fund medically necessary Medicaid abortions, particularly the susceptibility of Black women to the pregnancy-related complications of sickle cell anemia. NCBL is concerned that the inability of indigent Black women to choose and obtain medically necessary abortions will have an adverse impact on their health and well-being.

FAILURE OF APPELLANT ILLINOIS TO PAY FOR ALL MEDICALLY NECESSARY MEDICAID ABORTIONS WILL DAMAGE THE HEALTH OF INDIGENT PREGNANT WOMEN.

At issue in this case is the ability of poor women to receive medically necessary abortions when they are pregnant and need this service to preserve their health. Medical conditions requiring medically necessary abortions include thrombophlebitis, diabetes, anemia, hypertension, pyelonephritis, malnutrition, cardiovascular disease, sickle-cell anemia, uterine fibroid tumors, ectopic pregnancy, liver disease, and hemorrhage. Appendix at pp. 104-29.

Fact patterns of threatened health damage to pregnant indigent women recur in post-Hyde Amendment cases throughout the country. In Roe v. Casey, 464 F. Supp. 487 (E.D. Pa. 1978), Plaintiff Roe was 23 years old and had intended to carry her pregnancy to term but suffered from hyperemsis gravidarum (excessive vomiting) which is complicated by pregnancy and resulted in an inability to digest food and constant abdominal pain. 464 F. Supp. at p. 490. A second plaintiff was 13 years old and needed an

abortion because her immature pelvis would cause difficult labor and probable internal damage, as well as an increased incidence of pre-eclampsia (toxemia). The third plaintiff had a history of psychiatric problems including hospitalization for attempted suicide, and if her pregnancy were carried to term, it would cause severe psychological damage.

In this case, Appellee JANE DOE is a 38 year old woman who has four children; she has varicose veins. Affidavit of David ZBARAZ, M.D., Appendix at p. 127. Because of her previous pregnancies, continuation of her current pregnancy would have presented a significant medical risk of increasing the varicosity, leading to increased swelling and pain. Appendix at p. 127. This could have required surgery to remove the veins to relieve the swelling and pain; it could also have developed into a blood clot.[1] Appendix at p. 127. Under Illinois' Medicaid policies, the surgery necessary to remove the veins is

1. Appellee DOE in fact had an abortion during a temporary injunction in this case.

reimbursable, but not an abortion to prevent the need for such surgery. However, the pro-childbirth policy that Appellant ILLINOIS claims as the basis of its refusal to fund this medically necessary Medicaid abortion is contradicted by its willingness to fund tubal ligations, for which the sole medical justification is to end the mother's procreative ability.

While DOE's physician, Dr. ZBARAZ, stated that the present condition of medical knowledge foreclosed his stating with certainty that pregnancy would have so exacerbated her varicose veins as to cause severe or long lasting health damage, he did assert that she had a signficiantly increased risk that these complications would endanger her health. Appendix at pp. 127-128. Thus, he concluded that an abortion was "medically necessary" for her. Appendix at p. 128.

//

//

By contrast, in D.R. v. Mitchell, 456 F. Supp. 609 (D. Utah 1978), plaintiff's physician merely indicated that abortion would be appropriate. As will be discussed subsequently, the states possess an extensive array of administrative devices for determining which abortions are medically necessary and which abortions are nontherapeutic.

Without Medicaid funding, a poor woman cannot afford a safe, medically necessary abortion. In 1977, the average cost of an abortion in the United States was $285.[2] On the other hand, the average Aid to Families with Dependent Children (AFDC) grant to an entire family was only $241 per month.[3]

2. Abortions and the Poor: Private Morality, Public Responsibility, Alan Guttmacher Institute, 1979, at 27. (Hereinafter Abortions and the Poor).

3. Abortions and the Poor at 27.

In Georgia, Louisiana and Missouri, abortions cost an average of $220, $178 and $211, respectively; on the other hand, AFDC benefits in those states averaged $104, $122 and $154 respectively, per family.[4]

The average cost of an abortion is equivalent to an average welfare family's budget allocation for food for three months or rent for four months.[5] The AFDC mother whose medically necessary abortion can not be financed by Medicaid faces the stark choice between damage to her own health, of eviction and malnutrition for her children and herself.[6]

4. Abortions and the Poor at 27. See the following abortion cases in these states: Doe v. Busbee, 471 F. Supp. 1326 (N.D. Ga. 1979); Emma G. v. Edwards, 434 F. Supp. 1048 (E.D. La. 1977), Reproductive Health Services v. Freeman, Slip Op. No. 79-1275, (8th Cir., 1-9-80).

5. Abortions and the Poor at 28.

6. Marilyn Bennett, Director, Center for Family Counseling, Jersey City, New Jersey, Abortions and the Poor at p. 28.

Furthermore, it is not possible for abortion providers to assume the burden of financing these abortions. Providers were already performing approximately 85,000 free or reduced cost abortions for poor women not eligible for Medicaid prior to the passage of the Hyde Amendment.[7] To make up the deficit caused by those states which already have cut off public funding of abortions, providers would have to increase the number of abortions they subsidize by more than three times. This they cannot do.[8] Nor can they rely on private charity for financing. Less than 1% of all annual expenditures for personal health care comes from private philanthropy, a decline from 4% in 1950.[9]

Thus, the real effect of the Illinois statute and the Hyde Amendment has been

7. Abortions and the Poor at 28.

8. Abortions and the Poor at 28.

9. Abortions and the Poor at 28.

to deny poor women the choice of abortions which are necessary for medical reasons.[10]

Appellants and their amici obstetricians maintain that alternative treatments are available for many of the medical conditions which constitute indications for abortion.[11] There is nothing in the record of this case to indicate that such alternatives would be of equal medical efficacy. Assuming arguendo that efficacy, all of these alternatives are predicated upon, inter alia, frequent access to ongoing medical care.[12]

10. "Let us not wait for some white rabbit to pop out of a hat and suddenly bring a bundle of cash onto the dusty living room of a poor family with no money for an abortion, because it is not going to be there." 113 Cong. Rec. S11044 (6-29-77), Sen. Birch Bayh.

11. See, e.g., Brief Amici Curiae of Certain Physicians, Professors and Fellows of the American College of Obstetrics and Gynecology in Support of the Appellants.

12. Appellee Dr. ZBARAZ states that care for high risk pregnancies means being seen by a physician once every two or three weeks for seven months, and once a (continued)

These theoretical alternatives to abortion are predicated upon the availability of physicians to provide these medical alternatives to poor women.

---

12. Continued.
week thereafter. Affidavit of DAVID ZBARAZ, Appendix at p. 131. Dr. ZBARAZ, however, cautions that even this course of treatment can only somewhat increase a woman's chances for avoiding damage to her health since the course of a patient's illness is not altogether controllable. Appendix at p. 130. Amici obstetricians stress the need for frequent patient-physician contact in alternative treatments. For example, mild toxemia (preeclampsia) may be treated by bed rest on an outpatient basis "provided the woman visits her physician often." Obstetricians' brief at p. 10. Cardiovascular disease in the pregnant patient requires "[f]requent visits to cardiologist and obstetrician/gynecologist." Obstetricians' brief at p. 7. Sickle cell hemoglobinopathy, which afflicts poor Black women, requires "[c]lose observation and frequent visits to a physician." Obstetrician's brief at p.5. Teenage pregnancy also requires a great deal of prenatal care, while for Von Willebrand's disease (a blood factor disorder), coagulation studies must be performed throughout pregnancy. Obstetricians' brief at pp. 4, 10. For many other kinds of complications, a physician must monitor on a continuous basis the intake of medication and/or diet in her/his pregnant patients. Obstetricans' brief at pp. 9, 11, 12, 13.

However, there is a critical shortage[13] of primary care physicians, nurse practitioners and physician assistants in poor communities in Illinois and throughout the country.

---

13. Appellant UNITED STATES, through its Department of Health, Education and Welfare, has defined "health manpower shortage" for primary medical care [42 C.F.R. §5.4, Appendix A, Part I, (1978)] as the following criteria:

"...One of the following conditions prevails in the area (a) It has a population-to-primary care physician ratio of at least 3,500:1; or (b) It has a population-to-primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has either unusually high needs for primary care or insufficient capacity of existing primary care providers.

"...Primary care manpower in contiguous areas is overutilized, excessively distant, or inaccessible to the population of the area (this includes whether physicians will accept Medicaid patients)."
(continued)

Applying DHEW's criteria, the City of Chicago's Health Systems Agency (HSA) has documented that 31 areas of the city are health manpower shortage areas, of which more than 50% are group 01 areas, representing more than 30% of Chicago's poor population.[14] The Chicago HSA further concluded that most of the poor areas of the city are medically underserved.[15] Furthermore, in analyzing the incidence of high risk pregnancies, three factors were identified by the HSA: the number of births to women under 20 and over 40 years of age,

13. (continued)
The degrees of shortage are organized into 4 classifications as follows:
Group 01 - 5,000:1 to no physicians in the area.
Group 02 - between 4,000 to 5,000 (population to physician)
Group 03 - between 3,500 to 5,000:1
Group 04 - between 3,000 to 4,000:1

14. Health Systems Plan for the City of Chicago, 1979-1980, p. VI(C.1)-20.

15. Health Systems Plan, p. IV-29.

the percentage of mothers beginning prenatal care after the first trimester of pregnancy, and the incidence of low birthweight (premature) babies.[16] The highest percentage of births to women under 20, the highest percentage of premature births and the highest percentage of mothers beginning prenatal care after the first trimester occurred in Chicago's poverty areas.[17] The highest rate of infant mortality, which was twice as high for Blacks as for whites, occurred in the poorest areas of the city.[18]

These problems are exacerbated by features endemic to Medicaid. First, many licensed physicians do not participate at all in Medicaid.[19] Second, some states impose durational limits on hospital stays and physician

16. Health Systems Plan, p. V-6.

17. Health Systems Plan, p. V-11.

18. Health Systems Plan, p. V-15.

19. Chavkin, D., "Trends in State Administration of Medicaid Programs" (HEW Health Care Financing Administration 1978) pp. xx, 50 (IL.), 120 (N.H.), 125 (N.J.), 168 (UT.).

visits.[20] Third, some states do not exercise their option to provide Medicaid coverage to "unborn children," and thus deny Medicaid coverage entirely to the mother for physician's visits and hospital care.[21]

Amici's proposed medical treatment for many of the medical complications at issue requires bed rest.[22] Bed rest is simply impossible for an indigent single parent with two small children.[23] Bed rest is equally

20. See for example, Virginia Hospital Assn. v. Kenley, 427 F. Supp. 781 (E.D. Va. 1977) and Data on the Medicaid Program (HEW Health Care Financing Administration, 1979) p. 11 (LA) and Curtis v. Page, No. 79-224 (N.D. Fla. 4-18-79).

21. Burns v. Alcala, 420 U.S. 575 (1975); Chavkin, D., "Trends in State Administration," pp. XXXI (NH, VA). This wholly denies Medicaid benefits during the pregnancy of a single mother with her first child.

22. Brief of Obstetricians at, e.g., pp. 6,7,10.

23. The average AFDC recipient is a single parent with two young children. 1975 Recipient Characteristics Study, DHEW, Social Security Administration, 77-11-777, pt.1, p.1.

impractical for a working mother.[24]

Most important to a mother with an existing family who faces serious medical complications is that abortions are substantially safer than even normal childbirths. Roe v. Wade, 410 U.S. 113, 149 (1973). What we are dealing with in this case is abnormal childbirth which vastly increases the damage to the mother's health. The stake at issue is the health of the patient. The Illinois statute has for all practical purposes precluded any medical decision based on the mother's health.[25]

24. 15% of AFDC recipients are employed while on AFDC. 1975 Recipient Characteristics Study, pt. 3, p.3. A recent study analyzes welfare and labor statistics which demonstrate that the average AFDC recipient is a low-wage working mother who is temporarily unemployed. Harrison, B., Welfare Payments and the Reproduction of Low Wage Workers and Secondary Jobs, in Dollars and Sense, (No. 53, Jan. 1980, pp. 12, 13).

25. The Illinois statute violates the purpose of the Medicaid and AFDC programs to assist recipients to attain or retain their capacity for independence and self-support. 42 U.S.C. §§1396, 601.

SUMMARY OF ARGUMENT

Appellant ILLINOIS' restrictions on the availability of Medicaid abortions limits this service to situations where the mother's life is endangered. Amici contend that this restriction violates two separate provisions of Title XIX of the Social Security Act -- the requirement to extend five mandatory medically necessary services to the categorically needy, and the prohibitions against discrimination in the availability of services on the basis of diagnosis or type of illness or condition.

Our brief is divided into three parts: medical necessity, non-discrimination, and whether federal funding limits repeal a state's Title XIX obligations.

II.

TITLE XIX REQUIRES STATES TO PROVIDE ALL MEDICALLY NECESSARY MANDATORY SERVICES.

A. The Statutory History

In Beal v. Doe, 432 U.S. 437, 444-445 (1977), this Court said:

> Although serious statutory questions might be presented if a state Medicaid plan excluded

> necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a state to refuse to fund unnecessary though perhaps desirable services.

Throughout the Medicaid statutes and the federal regulations, one factor is emphasized and reemphasized -- that of medical necessity. It or its equivalent appears in the enabling act, the state plan requirements, the reimbursement provisions, the definitions and the provisions which set up the mechanism for determining medical necessity at least twenty-two separate times.[26]

In 1965, Congress established Medicaid:

> [The Senate Finance Committee] has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation, [Kerr-Mills program] because of the failure of some States to provide coverage

---

26. 42 U.S.C. §1396, §1396a(a)(10)(C)(1), (13)(B), (14), (17), (19), (20)(B), (26)(A),(B),(28),(30),(31),(33), §1396b(g), §1396d(a)(vii)(4)(B), (h), §1320c(1),(2), §1320c-4(a)(1), §1320c-5(b),(d), §1320c-9(a)(1),(2), (b)(3), §1320c-20, §1320c-21.

> and services to the extent anticipated... a more comprehensive Federal program as to both persons who can qualify and protection afforded is required. Sen. Rept. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1 U.S. Code Cong. & Admin. News 1943, 1964. (emphasis added).

Congress required participating states to extend the basic five mandatory services[26A] to all categorically needy aged, disabled, blind and dependent children welfare recipients. 42 U.S.C. §1396a(13). This differed from the Kerr-Mills program in which the states were required to provide only "some institutional and some non-institutional" care.[27]

Amici states contend that nowhere does Title XIX require the states to extend all medically necessary care even within the mandatory service categories. Amicus brief of Commonwealth of Massachusetts (hereinafter "amici states") at

26A. Inpatient and outpatient hospital services, x-ray and laboratory services, physician services, skilled nursing care.

27. Sen. Rept. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1 U.S. Code Cong. & Admin. News 1943, 1950.

pp. 10-43. In fact, as far back as 1960 in the House Report on H.R. 12580, the Kerr-Mills bill, the House stated:

> 2. Services provided
> Medical services eligible for Federal participation are defined in the new title to include, when determined by a physician to be medically necessary, inpatient hospital services with Federal participation in the costs...skilled nursing home services; physicians' services; outpatient hospital services... House Rept. No. 1799, 86th Cong.,2d Sess. (1960), 7.[28]

In 1965 Congress curtailed the states' discretion in the Kerr-Mills program by requiring an irreducible minimum of five basic service categories. 42 U.S.C. §1396a(a)(13)(B),(C)(i). While Congress gave the states the option to the extent practicable under the conditions of each state to include the optional medically needy eligibles and the optional services, 42 U.S.C.

28. Kerr-Mills, as did Title XIX, transposed "medically necessary care" into the phrase, "necessary medical services" in the actual wording of the statute. 42 U.S.C. §1396 (Medicaid); 42 U.S.C. §301 (1960) (Kerr-Mills).

§1396a(a)(10) and (13), the states were required during the period from 1965 to 1975 to make progress towards a comprehensive medical assistance program of all the optional eligibles and all the optional services, including preventive and rehabilitative care. 42 U.S.C. §1396a(d)(repealed).[29]

By 1972, the states had convinced Congress that progress toward a comprehensive medical assistance program was wreaking such fiscal havoc on their budgets that they were exempted from the requirement to provide eventually all optional services and all optional eligibles. Sen. Rept. No. 92-1230, 92d Cong., 2d Sess. (1972), 202.

They were not, however exempted from the requirement to provide all medically necessary mandated services to the categorically needy. Instead, Congress created an elaborate series of mechanisms

29. In 1969, the states were given a two year extension on the requirement for covering all the optional eligibles and services. Sen. Rept. No. 91-222, 91st Cong., 1st Sess. (1969), reprinted in 1 U.S. Code Cong. & Admin. News 1077, 1082.

to allow the states to control the provision of medically unnecessary services. These mechanisms are known as prior approval, Professional Standards Review Organizations (PSROs) and Utilization Review (U.R.).[30] What is common to each of these mechanisms is reliance upon the professional judgment of physicians to control the over-utilization of services by their peers. The judgment that these physicians were to exercise was whether the service was "medically necessary":

> [T]he PSRO's responsibilities are confined to evaluating the appropriateness of medical determinations so that Medicare and Medicaid payments will be made only for medically necessary services which are provided in accordance with professional standards of care. Sen. Rept. No. 92-1230, 92d Cong., 2d Sess. (1972), 261.

Thus, the tension between progress toward a comprehensive program and assuring an irreducible minimum of

30. 42 U.S.C. §1396a(a)(30),(31),(33), §§1320c,1320c-21, §1396b(g). These statutes are riddled with the concept of medical necessity.

services was resolved in the PSRO legislation in favor of providing only medically necessary services in the mandated service categories to the mandatory eligibles[31] (though a state was still free to include optional services and eligibles if it so desired). The Committee was convinced that effective utilization control techniques would be sufficient to preserve the integrity of the basic five service categories:

> ...in hearings conducted by the sub-committee on medicare and medicaid [w]itnesses testified that a significant portion of the health services provided under medicare and medicaid are probably not medically necessary. ... Aside from the economic impact . . . [u]nnecessary hospitalization and unnecessary surgery are not consistent with proper health care. Sen. Rept. No. 92-1230, 92d Cong., 2d Sess. (1972), 254.

The statutory requirement to provide all medically necessary mandated services does not mean that a state Medicaid program must pay for every form of medical care available under the mandatory services. For example, most forms of preventive care, routine check-ups, and the like are mandated for children under 21 (EPSDT), but are wholly optional for adults. 42 U.S.C. §1396d(a), 42 C.F.R. 440.50 and .130(C)(4) and (13). Nor does this require the states to pay for all forms of cosmetic, elective, and unnecessary surgery.[32] Instead, the states are required and authorized to implement controls over surgery which is not medically necessary.[33]

31. It is instructive to note two other 1972 changes. First, while the states were given the authority to impose cost sharing, they were forbidden to do so on the mandatory services to the mandatory eligibles. 42 U.S.C. §1396a(a)14(A). Secondly, state expenditures for mental health which were not originally covered under Medicaid were given a financial bailout but only on the express condition that services extended were medically necessary to improve the patient's condition. 42 U.S.C. §1396d(h).

32. Medical Society of New York v. Toia, 560 F.2d 535 (2d Cir. 1977).

33. Cost and Quality of Health Care: Unnecessary Surgery, Report by the Subcommittee on Oversight and Investigation of the Committee on Interstate and Foreign Commerce, 94th Congress, 2d Sess., (1976) pp. 18-26; 42 U.S.C. §1396a(a)(30).

B. The Case Law

Amici will examine four relevant lines of authority. The first line of authority holds that Medicaid programs must cover at least medically necessary care for the mandatory services.[34]

34. Pennsylvania Welfare Rights Organization v. Shapp, 602 F.2d 1114 (3d Cir. 1979) [EPSDT Orthodontia services]; Doe v. Kenley, 584 F.2d 1362 (4th Cir., 1978) [abortion]; Roe v. Norton, 380 F. Supp. 726 (D. Conn. 1974), 522 F.2d 928 (2d Cir. 1975) [dissenting opinion on abortion] rev'd on other grounds sub nom Maher v. Roe, 432 U.S. 464 (1977); Doe v. Beal, 523 F.2d 611 (3d Cir. 1975) [abortion] rev'd on other grounds sub nom Beal v. Doe, 432 U.S. 438 (1977); Doe v. Busbee, 471 F. Supp. 1326 (N.D. Ga. 1979) [abortion]; Doe v. Pickett, Slip Op. No. 79-322H, (S.D.W.Va. 11-30-79)[family planning]; Roe v. Casey, 464 F. Supp. 487 (E.D. Pa. 1978)[abortion]; Rush v. Parham, 440 F. Supp. 383 (N.D. Ga. 1977) [transsexual surgery]; Coe v. Hooker, 406 F. Supp. 1072 (D.N.H. 1976) [abortion]; Roe v. Ferguson, 389 F. Supp. 387 (S.D. Ohio 1974) [abortion] rev'd on other grounds, 515 F.2d 279 (6th Cir. 1975); Smith v. Vowell, 379 F. Supp. 139 (W.D. Tex. 1974) [transportation]; Morris v. Williams, 67 Cal.2d 733, 63 Cal. Rptr. 689 (1967)[cutback in physicians' and hospital services]; Curtis v. Page, Slip Op. No. 79-2244 (N.D. Fla. 4-18-79)
(continued)

The second line allows the states to draw an across-the-board standard for the mandatory services at somewhat less than all medically necessary care, provided that all diagnoses and conditions are treated equally.[35] In the third

34. continued
[physicians' services]; Monmouth Medical Center v. State of New Jersey, 80 N.J. 299 (N.J. Sup. Ct. 1979) [long-term hospital stays]; Right to Choose v. Byrne, 169 N.J. Super. 543 (N.J. Super. Ct. 1979) [abortion]; Ferro v. Lavine, 79 Misc.2d 431 (Sup. Ct., NY. Chenango Cty. 1974) [sterilization]; G.B. & J.D. v. Lackner, 80 Cal.App.3d 64 (1978) [transsexual surgery]; Doe v. State Dept. of Public Welfare, 257 N.E.2d 816 (Minn. 1977) [transsexual surgery]; Pinneke v. Preisser, CCH Medicare-Medi- caid Guide, ¶29,756 (N.D. Iowa 1979) [transsexual surgery]; Kleinwachter v. Dept. of Health & Social Services, CCH Medicare-Medicaid Guide, ¶27,383 (Dane County, Wis. Cir. Ct., 4/8/75) [mammary reconstruction]; Brooks v. Smith, 356 A.2d 723 (Me. 1976) [EPSDT Orthodontia services].

35. Zbaraz v. Quern, 596 F.2d 196 (7th Cir. 1979) [abortion]; Preterm v. Dukakis, 591 F.2d 121 (1st Cir. 1979) cert. denied ____U.S. ____, 99 S. Ct. 2181-2 (1979) [abortion]; White v. Beal, 555 F.2d 1146 (3d Cir. 1977)[eyeglasses]; Roe v. Norton, 522 F.2d 928 (2d Cir., 1975) [abortion]
(continued)

line of cases, plaintiffs failed to show that Medicaid recipients were being denied medically necessary care; these are hereinafter referred to as the reimbursement cases.[36] The fourth

35. continued
rev'd on other grounds sub nom Maher v. Roe, 432 U.S. 464 (1977); Simpson v. Wilson, Slip Op. No. 77-261 (D. Vt. 10-26-79); Frieman v. Walsh, Slip Op. No. 77-4171-CV-C (W.D. Mo. 1-26-79)[abortion] rev'd on other grounds sub nom Reproductive Health Services v. Freeman, Slip Op. No. 79-1275 (8th Cir. 1-9-80); Lady Jane v. Maher, 420 F. Supp. 318 (D. Conn. 1976) [abortion]; Denise R. v. Lavine, 347 N.E.2d 893 (N.Y. Sup. Ct. 1976) [transsexual surgery]; Hodgson v. Bd. of County Commissioners, Slip Op. No. 79-1665 (8th Cir. 1-9-80) [abortion: straddles both first and second lines of authority]; Women's Health Services v. Maher, Slip. Op. No. H-79-405 (D. Conn. 1-7-80)[abortion].

36. DR v. Mitchell, 456 F. Supp. 609 (D. Utah 1978) [abortion]; Virginia Hospital Assn. v. Kenley, 427 F. Supp. 204 (E.D. Va. 1977); Metropolitan Hospital v. Pennsylvania, 21 Pa. Commonwealth 116 (1975); Penn. Dept. of Public Welfare v. Temple University, CCH Medicare/Medicaid Guide ¶27,589, 21 Pa. Commonwealth 162 (9/8/75); Idaho Corp. of the Benedictine Sisters v. Marks, CCH Medicare/Medicaid Guide ¶29,768 (D. Ida. 8/29/73); District of Columbia Podiatry Society v. District of Columbia, 407 F. Supp. 1259 (D. D.C. (continued)

concerns the scope of, and mechanisms for determining medical necessity.[37]

The decisions holding that the states must at an irreducible minimum provide

36. continued
1975). These cases are best understood by realizing that 1) they were reimbursement cases and 2) there was no showing that any Medicaid patient was being denied or being forced to pay out of pocket for a medically necessary mandatory service. Contrast, for example, the results in the Monmouth Medical Center case, where the Court found that medically necessary care would be denied unless reimbursement for administratively necessary days was ordered, with the holding in Temple University: "The Medical Assistance Program in which Temple has agreed to participate obligates the hospital to provide non-reimbursable care after the expiration of the 60 day benefit period and thus no medically necessary care was denied to its patients." CCH Guide ¶27,589 at 10,422. Similar lack of evidence of the denial of medically necessary care underlies the findings in Kenley, 427 F. Supp. at 783, D.C. Podiatry Society, 407 F. Supp. at 1265 n.27 and 1268 n.43, and DR v. Mitchell, 456 F. Supp. at 610.

37. Doe v. Bolton, 410 U.S. 179, 192 (1973); Drennan v. Harris, 606 F.2d 846 (9th Cir., 1979); Medical Society of New York v. Toia, 560 F.2d 535 (2d Cir., 1977); Mount Sinai Hosp. v. Weinberger, 517 F.2d 329 (5th Cir. 1975) rev'g in (continued)

medically necessary services to the categorically needy are based on the following grounds: (1) the pervasive use of the phrase medical necessity or its equivalent throughout the statutory framework,[38] (2) the common antecedents of the Medicare and Medicaid programs in requiring medically necessary care,[39]

37. continued
part 376 F. Supp. 1099 (D. Fl. 1974); Szekely v. Florida Medical Assn., 517 F.2d 345 (5th Cir. 1975); Hultzman v. Weinberger, 495 F.2d 1276 (3d Cir. 1974); McMahon v. Califano, 476 F. Supp. 978 (D. Mass. 1979); Greater New York Hosp. Assn. v. Blum, 476 F. Supp. 234 (E.D.N.Y. 1979); Public Citizen Health Research Group v. H.E.W., 449 F. Supp. 937 (D. D.C. 1978); Dodson v. Parham, 427 F. Supp. 97 (N.D. Ga. 1977); Westgard v. Weinberger, 391 F. Supp. 1011 (D. N.D. 1975); Allen v. Richardson, 366 F. Supp. 516 (E.D. Mich. 1973); Price v. Putnam, Slip Op. No. 1288 (Or. Ct. App. 4-18-79); Smith v. Trainor, Slip Op. No.76 C 526 (N.D. Ill. 10-19-79).

38. E.g., Roe v. Casey, 464 F. Supp. 487.

39. E.g., Roe v. Norton, 591 F.2d at pp. 931-2, 935 n.5, 939-40 (dissenting opinion); Medicare and Medicaid share a common requirement of covering medically necessary services, see Turecamo v. Commr., Internal Revenue, 554 F.2d 564, 572-5 (2d Cir. 1977).

(3) the use of the phrase medical necessity or its equivalent in the Medicaid regulations,[40] (4) the 1972 amendments' reaffirmation of the states' duty to maintain the integrity of the basic five services for the categorically needy,[41] (5) the overwhelming concern for preserving the autonomy of the patient-physician relationship from review by non-physician bureaucrats.[42] As previously discussed, these concerns are well born out by the legislative history of the program.

Appellants and amici states base their argument that they may choose out of the mandatory services the conditions and treatments which they wish to provide on the following: (1) the phrase "as far practicable under the conditions of the state" which appears in the appropriations statute, (2) the phrase "reasonable standards...for determining

40. E.g., Preterm v. Dukakis, 591 F.2d 121.

41. E.g., Doe v. Beal, 523 F.2d 611.

42. E.g., Doe v. Busbee, 471 F. Supp. 1326; Rush v. Parham, 440 F. Supp. 383.

...the extent of medical assistance under the plan" in §1396a(a)(17), (3) the phrase "part or all of the cost of the following services," §1396d(a), (4) the notion that "medical necessity" ought to be subject to revision by state legislatures. In all of these arguments they are mistaken.

In 1965 the states were mandated to cover the basic five services for the categorically needy and given the option of covering the optional services, the optional eligibles, and preventive care for adults "as far as practicable under the conditions in the state" with the proviso that by 1975, regardless of the practicability of conditions in their state, they were mandated to provide comprehensive care to both mandatory and optional eligibles. 42 U.S.C. §1396a(a)(13)(B), (C),§1396b(e), §1396d(a)(vii)(6-17).[43] That is, by 1975 they were required to provide both medically necessary as well as preventive and

43. Sen. Rept. No. 91-222, 91st Cong., 1st Sess., (1969), reprinted in 1 U.S. Code Cong. & Admin. News 1077,1081.

rehabilitative care. The phrase "as far as practicable under the condition of the state" was not intended to modify the mandatory requirement to cover the basic five services, but rather to modify the state's obligation to progress from the irreducible minimum to a program of comprehensive care. This reading is reinforced by the congressional actions of 1972 which (1) lifted the requirement to provide a program of comprehensive care to the optional eligibles, (2) did not tamper with the obligation to provide the irreducible minimum to the categorically needy, and (3) provided the states with the mechanisms and obligation to sort out medically necessary from medically unnecessary care among the mandatory services. 42 U.S.C. §1396a(a)(13)(B),(C),(31),(33), §1396b(e),(g), §1320c et seq.

The phrase "reasonable standards ... for determining ... the extent of medical assistance under the plan" has been read variously as having no meaning since it appears in a paragraph concerned with setting the standards for eligibility, or as granting broad discretion to the state

by the use of the words "reasonable" and "objectives of the Act." It is true that 1396a(a)(17) is principally concerned with the setting of income eligibility, and its implementation is found at 42 C.F.R. 435.3 et seq. However, it also governs a state's decisionmaking on the extent of services,[44] and its "reasonableness" language is the basis for the regulatory prohibition against discriminations in mandatory service categories based on diagnosis, type of illness or condition, and that the scope of each optional service must be reasonably sufficient to achieve its purpose.[45] 42 C.F.R. 440.230(b). However, it is a profound misunderstanding of the language to read the phrases "reasonableness" and "objectives of the Act" and "as far as practicable" together as the First Circuit did in Preterm v. Dukakis, 591

44. 42 U.S.C. §1396a(a)(17) provides in part the statutory basis for 42 C.F.R. 440.230 with regard to comparability of services.

45. Solicitor General's brief at pp. 43-44, n. 23.

F.2d at 124-5, to give the states discretion to invade the integrity of the five basic "medically necessary" services for the categorically needy. The objective of Medicaid was to over-ride the states' prior history of not providing medically necessary basic services to the categorically needy and to ensure that out of their subsistence incomes, welfare recipients would not have to pay for the costs of medically necessary care in the five basic services.[46] If the statutory interpretations espoused by amici states and the First Circuit are adopted, we will soon see state efforts, similar to those enjoined in Curtis v. Page, Slip Op. No 79-2244, where Florida attempted to limit all physicians' services to care necessary to save life or limb -- an approach that was rejected by

46. See 42 U.S.C. §§1396a(a)(14)(A) and 1396a(c) and 42 C.F.R. 447.15 and 447.53; Crane v. Mathews, 417 F. Supp. 532 (N.D. Ga. 1976).

Congress[47] and by this Court,[48] and strongly criticized by the First Circuit.[49]

The phrase "sufficient ... to reasonably achieve their purpose" in 42 C.F.R. 440.230 must also be read in context. It applies to optional services as well as to the mandatory services. Some of the optional services, e.g., podiatrists' services, are inexpensive alternatives to higher cost mandatory services. A state could properly, pursuant to the purposes of §1396a(a)(30), provide podiatrists' care for certain services because it is cost-efficient, while restricting its availability for others, provided that medically necessary care is available from either a physician or a podiatrist.[50] An abortion,

47. See earlier discussion of legislative history.

48. Memorial Hospital v. Maricopa County, 415 U.S. 250, 260-1 (1974).

49. Preterm v. Dukakis, 591 F.2d at 126.

50. District of Columbia Podiatry Society v. District of Columbia, 407 F. Supp. at 1265, n. 27, 1268, n.43.

however, can be performed only by a physician, whose judgment on medical necessity is to be reviewed only by other physicians within the utilization control framework. The Illinois legislature has sought to interfere with that professional judgment by limiting it to only one factor, life endangerment; this is not sufficient to reasonably achieve the purpose of protecting a woman's health.

The phrase "part or all of the cost of the following services," appearing in 42 U.S.C. §1396d, is relied on by the amici states to argue that they can pay none of the cost of a treatment falling into one of the mandatory categories. This fails to read the statute as a whole. "Part or all" refers to (1) the state's authority to impose cost-sharing on all services to the optionally needy and (2) the states' obligation to treat income flexibly by granting a deduction in determining eligibility for incurred medical expenses (i.e., a "spenddown").[51]

51. See Sen. Rept. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1 U.S. Code Cong. & Admin. News 1943, 2018; 42 U.S.C. §1396a(a)(14)(A), (17)(D).

Lastly, amici states contend that the resolution of medical necessity in this case could bind state legislatures' efforts to control Medicaid costs.[52] However, (1) Congress did require states to make a commitment to provide the irreducible minimum of five basic services to the categorically needy, (2) Illinois' and the amici states' interpretation of the statute makes an absolute nullity of that commitment and (3) Congress has mandated the states to set up three separate programs to control medically unnecessary utilization of the mandatory services.

It is important to seek to understand what medical necessity is and how it is determined. In D.R. v. Mitchell, 456 F. Supp. 609, Judge Anderson stated that it was such an elusive and meaningless[53] concept that it could not have been

52. See, e.g., Amicus brief of the State of New Jersey at pp. 1-2.

53. American Association of Physicians and Surgeons v. Weinberger, 395 F. Supp. 125,138 (N.D. Ill. 1976) found that "medically necessary" was not a unconstitutionally vague concept.

imposed as a requirement of the Medicaid statutes, thereby ignoring the twenty-two times it or its equivalent is mentioned. By contrast, this court stated in Doe v. Bolton, 410 U.S. 179, 192, (1973) that "whether an abortion is necessary is a professional judgment that may be exercised in the light of all factors -- physical, emotional, psychological, familial and the woman's age -- relevant to the well-being of the patient...[t]his allows the attending physician the room he needs to make his best medical judgment." Medical necessity is in reality good, sound, conservative medical practice. It is a term of art given definition with increasing certitude through the experience of the PSROs, U.R. Committees, and the medical committees of the fiscal intermediaries in applying it to bills submitted for payment in the Medicaid and Medicare programs.[54] These utilization criteria must be developed after studies and "analysis of patterns of patient care"; they are developed by health professionals relying

54. 42 U.S.C. §1320c-20(a)(1).

on the professional health care literature and their own expertise; they must be based on "regional medical care appraised norms" which are "numerical or statistical measures of usually observed performance," 42 C.F.R. 456.51(b) and .141. Their application is done after review of the patient's records and in long term care in conjunction with periodic inspections of the facility and personal contact with the patient. 42 C.F.R. 456.111 and 456.608. In short, the assessments of medical necessity are scientific and professional; they are based on actual patient experience. Furthermore, they are evolutionary, reflecting the state of the art at any given point in time and removing "outliers" -- practitioners or institutions with abnormal practice patterns reflecting over-utilization.

The state agency is held at arm's length from the determination of medical necessity. 42 C.F.R. 456.6, 463.10. In fact the determination of medical necessity is binding on the state agency, unless it is an uncovered individual or uncovered service. 42 C.F.R.

463.16(C)(1), 463.27. Furthermore, fiscal constraints are not a permissible ground for denial of coverage. Price v. Putnam,Slip. Op. No. 1288; Mead v. Burdman, CCH Medicare Medicaid Guide ¶28,957 (King Cty. Super. Ct., Wash. 3/20/78).

Since Congress was concerned with minimizing the intrusive effect of government financing into the private patient-physician relationship,[55] federal and state efforts to displace the PSRO determination either by state personnel or administrative rule-making have generally not been successful. Greater New York Hosp. Assn. v. Blum, 476 F. Supp. 234 (E.D.N.Y. 1979), McMahon v. Califano, 476 F. Supp. 978 (D. Mass., 1979), Allen v. Richardson, 366 F. Supp. 516 (E.D. Mich. 1973). The state effort to regulate the medical criteria for funding abortions is a harbinger of state efforts to withdraw both the criteria and treatment for a variety of other medical conditions from the province of the PSRO where it was placed by Congress.

55. Sen. Rept. No. 92-1230, 92d Cong., 2d Sess. (1972), 246; Turecamo v. Comr. of Internal Revenue, 554 F.2d 564.

III

RESTRICTIONS ON THE AVAILABILITY OF SERVICES MUST BE BASED ON ACROSS-THE-BOARD STANDARDS DRAWN IN AN EVEN-HANDED FASHION WITHOUT DISCRIMINATION BASED ON DIAGNOSIS, TYPE OF CONDITION OR ILLNESS.

The federal regulations prohibit states from discriminating in their provision of services based on diagnosis or type of condition. They provide in relevant part:

> (1). The medicaid agency may not arbitrarily deny or reduce the amount, duration or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.
> (2) The agency may place appropriate limitations on a service based on such criteria as medical necessity or on utilization control procedures. 42 C.F.R. 440.230(c).

Physicians and hospital services are mandatory services under 42 C.F.R. 440. .10,.20,.50, and .210. Restrictions on abortion funding to situations where the mother's life is endangered are reductions in the amount or scope of a service based solely on diagnosis or type of condition.[56]

56. See cases cited in notes 34 and 35.

Prohibitions against discrimination on the basis of type of condition were first elucidated by HEW in 1966 in the Handbook of Public Assistance Administration, Supplement D, based on statutory requirements.[57]

The Illinois restrictions at issue mean that a woman suffering phlebitis can have a sterilization one day prior to discovering she's pregnant, but one day after this discovery, she cannot have an abortion to preserve her health. She can give up her entire childbearing capacity but not a single pregnancy that would damage her health.

Illinois' policy cannot be justified as based on "medical necessity or on utilization control procedures." 42 C.F.R. 440.230(c)(2). Furthermore, the phrase "medical necessity" was inserted into this regulation in 1974 after HEW

57. 42 U.S.C. §1396a(a)(17) requires the states to use reasonable standards for determining the extent of medical assistance. Section 1396a(a)(19) requires administration in the best interests of recipients. Section 1396a(a)(10) prohibits discrimination in the extent of services between groups of eligibles.

had extensive experience with its meaning as applied by U.R. Committees, fiscal intermediaries and PSROs. In none of these contexts does it have anything in common with Illinois' standard,"life threatening". The further deficiency in the Illinois statute is that it does not turn over the decision as to which abortions are medically necessary to medical peer review groups, as required in the federal statutes and regulations.

The reasoning of the First, Third, Seventh and Eighth Circuits requires a holding that Illinois' abortion policy violates federal regulations. In Preterm v. Dukakis, 591 F.2d 121, the First Circuit held that while the state had latitude to set the degree of medical necessity for which it would reimburse, it could not vary the degree of medical necessity based on the particular kind of medical condition being treated. See also Zbaraz v. Quern, 596 F.2d 196; Hodgson v. Bd. of County Commissioners, Slip. Op. No. 79-1665. Similarly, in White v. Beal, 555 F.2d at 1151, where Pennsylvania limited its optional

eyeglasses program to persons suffering eye disease but not to persons suffering from equally poor vision due to genetically poor eyesight, the Third Circuit held:

> We find nothing in this federal statute that permits discrimination based upon etiology rather than need for the service ... The state plan's classification is arbitrary since it is based upon a factor not reasonably related to medical need ... [T]he service must be distributed in a manner which bears a rational relationship to the underlying federal purpose of providing the service to those most in need of it. (emphasis added)

Under this approach (and disregarding for the moment the requirement to provide all medically necessary mandated services), Illinois cannot restrict the availability of abortions to life-threatening situations unless it is willing to restrict all of its hospital and physician's services and arguably all of the other mandatory and optional services to a comparable standard.

IV.

THE WITHDRAWAL OF FEDERAL FUNDING FOR A SERVICE IS NOT TANTAMOUNT TO A PRO TANTO REPEAL OF THE MEDICAID STATUTES.

The overall question is best posed as follows: Can a state escape its obligations under Title XIX simply because there is or is not a particular amount of federal funding forthcoming? Amici contend the answer should be "no". A series of broader policy disputes are involved in this answer among Congress, HEW and the states in the following: closing of nursing homes due to life, safety and code violations,[58] enforcement of utilization review,[59] enforcement of children's services (EPSDT),[60] payment of old claims,[61] Medicare buy-ins,[62]

58. Feld v. Berger, 424 F. Supp. 1356, 1357 (S.D.N.Y. 1976).

59. 42 U.S.C. §1396b(g).

60. 42 C.F.R. 441.70; 45 C.F.R. 201.14(a)(3).

61. 42 C.F.R. 447.45(d)(4), 431.250(e).

62. 42 U.S.C. §1396b(b)(1); 42 C.F.R. 449.41(c); GAO Report H.R.D. 79-96, Simplifying the Medicare-Medicaid Buy-In Program, 1979.

error rates,[63] requirements to assure transportation and emergency medical care,[64] due process notice and hearing guarantees[65] and the like.

Generally, federal funding is used as both a carrot and stick by Congress and HEW; the states' contention is that it may be used only as a carrot, and that each activity required of the states must be scrutinized for its impact on federal medical assistance percentage.[66]

Federal financial participation (FFP) is a patchwork quilt of variable funding percentages.[67] For example, most

63. 42 U.S.C. §603(j); 42 C.F.R. 438.801.

64. 42 C.F.R. 431.53; DHEW Medical Assistance Manual 6-20-00(B-E); 45 C.F.R. 206.10(a)(5); 42 C.F.R. 435.930.

65. 44 C.F.R. 435.1003; Stenson v. Blum, Slip. Op. Civ. No. 78-6044 (S.D.N.Y. 9-18-79);

66. 42 U.S.C. §1396b(a)(1); 42 C.F.R. 433.10(b).

67. The descriptions and limitations on FFP are found at 42 C.F.R. 431.591, .592, and .597; 432.50; 433.10, .15, .112-.114; 435.1001-.1011, 440.21; 441.11 and .13; 447.35 and .252.

services are funded at ratios from 50 to 83%,[68] depending on the comparative wealth of the state. However, transportation services are funded at 0 to 90%, depending on the state's choice of how to provide transportation.[69] Moreover, in the Medicare buy-in amounts for the medically needy, the states must use 100% state funds and failing that, they will be docked the entire FFP for the services for which they failed to buy-in.[70] By way of contrast, family planning services are funded at 90%,[71] and services to a decertified nursing home are funded at 0%.[72] Administrative costs are funded at rates ranging from 50% to 100%, depending on the activity being performed.[73]

68. 42 C.F.R. 433.10(b).

69. DHEW Medical Assistance Manual 6-20-00 (C-E).

70. 42 U.S.C. §§1396a(a)(15), 1396b(b)(1); 42 C.F.R. 431.625.

71. 42 C.F.R. 433.15(c)(1).

72. 42 C.F.R. 441.11.

73. 42 C.F.R. 432.50, 433.15.

Inspections of nursing homes receive 100% reimbursement.[74] Personnel involved in developing mechanized claim processing or family planning services receive 90%.[75] Skilled professional medical personnel and managers of the claims processing systems qualify for 75% reimbursement, while skilled non-medical personnel qualify for only 50% reimbursement.[76]

Additionally, there are at least three separate areas where Congress and HEW have threatened to reduce federal funding dramatically if the states fail to 1) run adequate utilization review programs, 2) comply with EPSDT requirements and 3) reduce their error rates.[77] Many states have contended (and some are currently suing HEW) that the federal medical assistance percentage is inviolate.

74. See n.73.

75. See n.73.

76. 42 C.F.R. 432.50; 433.15.

77. 42 U.S.C. §1396b(g),§603(f),(g),(j).

Turning to some specific examples where the state can properly assert that the FFP is 0, the question must be posed whether the lack of FFP relieves the state's obligations. If this Court adopts the position of Appellant ILLINOIS and the amici states, the necessary implication militates toward the states' being relieved of their obligations in the following examples:

Example 1
The 12 month time limit for FFP[79] in Medicaid bill payment has lapsed. Its lapse is due to either litigation, oversight by the state, or mistake of the provider, recipient or the state. Is the state relieved of its obligation to pay the provider's bill, or alternatively to hold the recipient harmless from the provider's efforts to collect the bill?

Example 2
The state has chosen to fulfill its obligation to assure transportation to medical providers by using other federal and state transportation funds available from the Department of Transportation at a better matching rate.[80] Is it

79. 42 C.F.R. 447.45(d)(4), 431.250(e).

80. DHEW Medical Assistance Manual 6-20-00(C)p.7.

relieved of its medical obligations to HEW and the recipient to assure high quality care and/or to assure that the recipient is not billed for service?

Example 3
The state is obligated to assure Medicaid applicants emergency medical care on a 7 days a week, 24 hours a day basis. The state has chosen not to provide the optional service of emergency medical care in hospitals not participating in Medicaid.[81] The patient is in a car accident and is treated at the nearest hospital which does not participate in Medicaid. After the application is approved, is the state obligated to pay the hospital bill or otherwise hold the recipient harmless against suit by the hospital?

Example 4
On termination of a Supplemental Security Income (SSI) recipient's benefits, the state agency has a limited number of days of FFP in which to conduct an investigation of ongoing Medicaid eligibility and send, if appropriate, a notice of reduction or termination of assistance.[82] When the state is unable to accomplish its tasks within the time limits due to

81. 42 C.F.R. 440.170(e), 431.52(b).

82. 42 C.F.R. 435.1003.

inadequacies of administrative structures in HEW and the state, is it relieved of its obligations under federal regulations and the Constitution to afford proper redetermination and notice procedures?[83]

Example 5
HEW orders a nursing home to be suspended from Medicare, which also terminates FFP under Medicaid within 2 months.[84] Due to the shortness of time, the state is unable to make adequate arrangements for the safe transfer of all the patients within the time limits for FFP. Is the state thereby relieved of any obligation for the patients' safe transfer and for the nursing home's costs in the interim?

What we are suggesting by these examples is that a state's obligation under the Medicaid program is not tied to whether it receives funding for any particular activity, but rather to its decision to participate in the Medicaid program and thus to accept the vagaries and approximations of overall federal funding

83. See Stenson v. Blum, Civ. No. 78-1044 (S.D.N.Y. 9-18-79).

84. 42 C.F.R. 441.11. See Feld v. Berger, 424 F. Supp. 1356.

for medically necessary care to its indigent population. In so doing, it sometimes receives 0% in FFP as in the examples cited above and as in other examples cited in appellees' brief, while in other contexts it receives 100% federal funding. These are the extremes; yet when viewed on an over-all basis, the state receives extremely generous federal funding to fulfill its historic duty to provide for its indigents.[85]

CONCLUSION

Amici urge this court to guarantee the right of the indigent pregnant mother and her doctor to reach a decision as to the most appropriate medically necessary treatment of her condition, free from the intrusion of the medically untrained judgments of state welfare officials and legislators. Amici urge this Court to affirm the Seventh Circuit's holding that state restrictions on the availability of medically necessary abortions violate Title XIX and federal regulations, and to reverse the holding of the Seventh

85. McRae v. Mathews, 421 F. Supp. 533, 537 (E.D. N.Y. 1976); Amici states' brief at p. 29.

Circuit that withdrawal of federal funding in the amount of less than .2% of Illinois' Medicaid budget is tantamount to a pro tanto repeal of the state's substantive obligations under Title XIX and the implementing federal regulations. Amici further urge this Court to affirm the holding of the District Court that Illinois' singular denial of funding for medically necessary abortions, while funding all other comparable medically necessary care, violates the Equal Protection Clause of the Fourteenth Amendment.

In reaching its decisions on these issues, amici urge that this Court consider carefully the impact of its holding on some of the myriad of issues not before this court involving the same and similar statutory provisions - state cutbacks in hospital and physician mandatory services, state cutbacks in prescription drugs and eyeglasses and other optional services, state denials of orthodontia and other medically necessary care to children under the EPSDT programs, state failures to assure transportation to necessary medical services,

and state failures to assure emergency medical care for applicants and recipients.

Respectfully submitted,

DOROTHY T. LANG
LUCIEN WULSIN, JR.
National Health Law Program
2401 Main Street
Santa Monica, CA 90405
(213) 392-4811
Attorneys for the Physicians National Housestaff Association

VICTOR GOODE
LAUREN ANDERSON
National Conference of Black Lawyers
126 W. 119th St.
New York, NY 10026
(212) 866-3501
Attorneys for the National Conference of Black Lawyers

VILMA S. MARTINEZ
CARMEN A. ESTRADA
Mexican American Legal Defense & Education Fund
28 Geary Street
San Francisco, CA 94108
(415) 981-5800
Attorneys for the Mexican American Women's National Association

M.D. TARACIDO
PETER BIENSTOCK
LIZETTE A. CANTRES
Puerto Rican Legal Defense & Education Fund
95 Madison Avenue
New York, NY 10016
(212) 532-8470
Attorneys for the Puerto Rican Legal Defense & Education Fund